**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-5824.M5**

MDR Tracking Number: M5-05-1162-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-14-04.

In a letter dated 3-15-05 the requestor withdrew dates of service 3-30-04 and 4-1-04. These dates will not be a part of this review.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that neuromuscular reeducation, office visits, therapeutic exercises, electrical stimulation and manual therapy technique from 4-19-04 through 8-13-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 2-8-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT codes 99212, 97112, 97032, 97140 and HCPCs Code E1399 for dates of service 3-23-04, 3-26-04, 4-6-04, 4-8-04, 4-13-04, 4-16-04, 6-9-04, 6-10-04, 6-11-04, 6-24-04, 7-7-04, 7-19-04 and 7-23-04 were denied as "850" – "services rendered appear to be unauthorized prior to treatment" or as "Z" – "Preauthorization requested, but denied." According to Rule 134.600(h) these services do not require preauthorization. **Recommend reimbursement as follows:**

CPT code 99212- $624.39 ($48.03 X 13 DOS)
CPT code 97112 - $735.00 ($36.75 X 20 units)
CPT code 97032 - $60.12 ($20.04 X 3 DOS)
CPT code 97140 - $101.73 ($33.91 X 3 DOS)
HCPCs code E1300 - $25.00 ($25.00 X 1 DOS)

CPT codes 97110 for dates of service 3-23-04, 3-26-04, 4-6-04, 4-8-04, 4-13-04, 4-16-04, 6-9-04, 6-10-04, 6-11-04, 6-24-04, 7-7-04, 7-19-04 and 7-23-04 was denied as "850" – "services rendered appear to be unauthorized prior to treatment" or as "Z" – "Preauthorization requested, but denied." Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this

Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy**. Reimbursement not recommended.**

**On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees from 3-23-04 through 7-23-04 totaling $1,546.24 outlined above as follows:**

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 31st day of March 2005.

Donna Auby

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

March 14, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

**NOTICE OF INDEPENDENT REVIEW DECISION**
**Amended Determination 3/30/05**

**RE: MDR Tracking #: M5-05-1162-01**
**TWCC #:**
**Injured Employee:**
**Requestor: Pain & Recovery Clinic**
**Respondent: Bankers Standard c/o Flahive Ogden & Latson**
**MAXIMUS Case #: TW05-0028**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient reported that while at work she injured her back when she attempted to lift a box weighing 20-30 lbs above her head. An MRI of the lower back performed on 9/13/03 revealed a 6mm herniation at that L4-L5 level and a 3mm herniation and annular tear at the L3-L4 level. The treating diagnosis for this patient includes displacement lumbar intervertebral disc without myelopathy. Treatment for this patient's condition has included epidural steroid injections and therapy consisting of neuromuscular reeducation, therapeutic exercises, electrical stimulation, and manual therapy technique.

Requested Services

Neuromuscular reeducation, office visit, therapeutic exercises, electrical stimulation, and manual therapy technique from 4/19/04 – 8/13/04.

Documents and/or information used by the reviewer to reach a decision:

*Documents Submitted by Requestor*:

1. Position Statement (no date)
2. MRI report 9/13/03
3. DDE 4/27/04
4. New Patient Evaluation 3/11/04
5. Comprehensive Pain Follow Up notes 6/29/04 and 8/17/04
6. Subsequent Medical Report 3/15/04, 8/20/04, 6/23/04,
7. Initial Medical Report 5/5/04
8. Therapy Reevaluation 6/29/04
9. Daily Progress Notes 3/23/04 – 8/13/04

*Documents Submitted by Respondent*:

1. IME report 1/19/04

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a female who sustained a work related injury on ___. The MAXIMUS chiropractor reviewer indicated that the patient had a 2 level disc herniation with mild radicular signs. The MAXIMUS chiropractor reviewer noted that the patient has no weakness or motor and sensory loss and that the patient's reflexes are normal. The MAXIMUS chiropractor reviewer indicated that the patient has been treated with conservative care and injections with no objective relief and only mild temporary relief after some of the injections. The MAXIMUS chiropractor reviewer also indicated that the patient had been evaluated numerous times by various specialists but that there was no change to her treatment plan after these evaluations. The MAXIMUS chiropractor reviewer explained that after the 4 months of care in question, there was no documented relief of the patient's pain level or increase in her range of motion. The MAXIMUS chiropractor reviewer also explained that after 4-6 weeks of initial treatment without documented improvement or change in the treatment plan, the care becomes not medically necessary. Therefore, the MAXIMUS chiropractor consultant concluded that the level III office visits, therapeutic exercises, neuromuscular reeducation, manual therapy techniques from 4/19/04 through 8/13/04 were not medically necessary to treat this patient's condition.

Sincerely,
**MAXIMUS**

Elizabeth McDonald
State Appeals Department